Date: [Insert Date]

To: [Insurance Company Name / Recipient Name]
Address: [Recipient Address]
Fax/Phone: [Recipient Contact Information]

RE: Letter of Medical Necessity for Dietary Modifications

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Insert Number]
Group Number: [Insert Number]

To Whom It May Concern,

I am writing to formally document the medical necessity of specific dietary modifications and nutritional support for the aforementioned patient, who is currently under my care for the management of **Congestive Heart Failure (CHF)** (ICD-10 Code: [Insert Code, e.g., I50.9]).

The patient's clinical status requires strict adherence to the following medical nutrition therapy:

- **Sodium Restriction:** Limit to [Insert Amount, e.g., 2,000mg] per day to prevent fluid retention and pulmonary edema.
- **Fluid Restriction:** Limit to [Insert Amount, e.g., 1.5L - 2L] per day to reduce cardiac workload.
- **Heart-Healthy Macronutrients:** Emphasis on high-quality protein and fiber to manage cachexia and comorbid metabolic conditions.

These dietary interventions are essential to prevent acute exacerbations of heart failure, reduce the frequency of hospital readmissions, and mitigate the risk of fluid overload. Without these modifications, the patient is at high risk for worsening dyspnea, peripheral edema, and acute decompensated heart failure.

Please provide coverage for the requested [Nutritional Counseling / Specialized Meal Delivery / Medical Supplements] as an integral component of this patient's treatment plan.

Should you require additional documentation or clinical records, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[NPI Number]

[Practice Name]
[Phone Number]